

Rhode Island 2019 Alternative Payment Methodology Plan Submitted to Health Insurance Commissioner Marie Ganim

January 24th, 2019

I. Background and Purpose

This 2019 Alternative Payment Methodology Plan is adopted pursuant to §4.10(D)(2) of 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner, by Marie Ganim, Health Insurance Commissioner.

The purpose of §4.10(D)(2) of 230-RICR-20-30-4 is to "significantly reduce the use of fee-for-service payment as a payment methodology, in order to mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services."

The APM Plan components, detailed below, are designed to provide incentives to move the Rhode Island marketplace away from the fee-for-service payment model and towards payment models that encourage high quality and lower cost of care. This plan was developed over the course of three Alternative Payment Methodology Advisory Committee meetings in the fall of 2018.

II. Definitions

1. "Alternative Payment Methodology" means a payment methodology structured such that provider economic incentives, rather than focus on volume of services provided, focus upon:

- Improving quality of care;
- Improving population health;
- Reducing cost of care growth;
- Improving patient experience and engagement, and
- Improving access to care.

To qualify as an APM, the payment methodologies must define and evaluate cost performance relative to a "budget" that may be prospectively paid or retrospectively reconciled. Providers are rewarded for managing costs below the budget, should quality performance be acceptable, by retaining some or all of the savings. Providers may also be responsible for some or all of the costs that exceed the budget.

While not meeting the foregoing definition of APM, certain pay-for-performance payments, care management payments, and infrastructure payments, as described below, will be credited toward achievement of the insurer's APM targets 3(a) and 3(b), below.

2. "Approved Alternative Payment Methodologies" include:

- Total cost of care (TCOC) budget models;
- Limited scope of service budget models;
- Episode-based (bundled) payments;
- Pay-for-performance payments;
- Supplemental infrastructure payments for patient-centered medical home functions, including care management, paid to PCPs or to ACOs;
- Supplemental infrastructure payments to specialists to provide incentives to improve communications and coordination among PCPs and specialists, and
- Other non-fee-for-service payments that meet the definition (a) above as approved by OHIC.

3. The Alternative Payment Methodology Plan specifies three targets for insurers to achieve.

(a) "Alternative Payment Methodology Target" means the aggregate use of APMs as a percentage of an insurer's annual commercial insured medical spend. The APM Target shall include:

- All fee-for-service payments under a population-based total cost of care contract with shared savings or shared risk;
- Episode-based (bundled) payments; primary care, specialty care or other limited scope-of-service capitation payments, and global capitation payments;
- Pay-for-performance payments, supplemental infrastructure payments for patient-centered medical home functions, including care management, paid to PCPs or to ACOs, and supplemental infrastructure payments to specialists to provide incentives to improve communications and coordination among PCPs and specialists, and
- Shared savings distributions.

(b) "Non-Fee-for-Service (FFS) Target" means the use of strictly non-fee-for-service alternative payment methodology payments as a percentage of an insurer's annual commercial insured medical spend. The Non-FFS target defined in this subsection 3(b) is a subset of the APM Target defined in subsection 3(a), above. The Non-FFS Target shall include:

- Episode-based (bundled) payments, either prospectively paid or retrospectively reconciled, where providers share in any losses (or gains);
- Limited scope-of-service capitation payments and global capitation payments (excluding the value of fee-for-service payments for services not covered by the capitation contracts);
- Pay-for-performance payments, supplemental infrastructure payments for patient-centered medical home functions, including care management, paid to PCPs or to

- ACOs and supplemental infrastructure payments to specialists to provide incentives to improve communications and coordination among PCPs and specialists, and
- Shared savings distributions.
- (c) “Risk-Based Contract Target” means the percentage of Rhode Island resident commercial insured covered lives attributed to a population-based contract that holds the provider financially responsible for a negotiated portion of costs that exceed a predetermined population-based TCOC budget, in exchange for provider eligibility for a portion of any savings generated below the predetermined budget, and (ii) incorporates incentives and/or penalties for performance relative to quality targets. Provider financial responsibility may be shared (Risk Sharing Contract) or wholly assumed by the provider (Global Capitation Contract).

Effective 2019, Risk-Based Contracts with 10,000 or more attributed lives must meet the following Minimum Downside Risk requirements to be counted towards the Risk-Based Contract Target defined in Section 3.

Following the general CMS (MACRA) methodology for “Other Payer Advanced APM” determinations, OHIC is adopting Minimum Downside Risk requirements which specify values for three common parameters of Risk-Based Contracts: risk exposure cap, risk sharing rate, and minimum loss rate. These parameters are defined as follows:

- **Risk exposure cap** is a cap¹ on the losses which may be incurred by the provider under the contract, expressed as a percentage of a) the total cost of care or b) the annual provider revenue from the insurer under the contract.²
- **Risk sharing rate** is the percentage of total losses shared by the provider with the insurer under the contract after the application of any risk exposure cap and/or minimum loss rate.
- **Minimum loss rate**, also called a “risk corridor”, is a defined percentage of the total cost of care, or annual provider revenue from the insurer under the contract, which must be exceeded before actual losses are incurred by the provider. Losses (or savings) may accrue on a “first dollar” basis once the “risk corridor” is breached.

Insurers are not obligated to employ a risk exposure cap or minimum loss rate in their Risk-Based Contracts. If they choose to do so, however, such contractors must adhere to the parameters set forth below.

Contracts with physician-based ACOs may employ a risk exposure cap that is tied to the annual provider revenue from the insurer under the contract or the total cost of care. Contracts with hospital-based ACOs are to employ a total cost of care methodology to satisfy the Minimum Downside Risk requirements.

¹ As a parameter of risk-based contracting, the risk exposure cap is a mechanism for limiting the total losses incurred by a provider, should the medical experience of its attributed population be adverse. The Minimum Downside Risk requirements establish a minimum value, or “floor,” for the risk exposure cap.

² Annual provider revenue refers to the service revenue and care management/infrastructure payments accruing to the provider for attributed patients under the Risk-Based Contract.

ACOs including Hospital Systems ³	Physician-based ACOs
<p>Between 10,000 and 20,000 commercial lives:</p> <p>Risk exposure cap: at least 4% of TCOC Risk sharing rate: at least 30% Minimum loss rate: no more than 3%</p>	<p>Between 10,000 and 20,000 commercial lives:</p> <p>Risk exposure cap: at least 6% of provider revenue or 2% of TCOC Risk sharing rate: at least 30% Minimum loss rate: no more than 3%</p>
<p>Over 20,000 commercial lives:</p> <p>Risk exposure cap: at least 5% of TCOC Risk sharing rate: at least 40% Minimum loss rate: no more than 2%</p>	<p>Over 20,000 commercial lives:</p> <p>Risk exposure cap: at least 8% of provider revenue or 3% of TCOC Risk sharing rate: at least 40% Minimum loss rate: no more than 2%</p>

The Minimum Downside Risk requirements above, while not applicable to population-based TCOC contracts with fewer than 10,000 attributed lives, should not be construed to preclude or discourage health insurers and providers from entering into contracts with downside risk for fewer than 10,000 covered lives. OHIC recommends insurer and provider caution when doing so, however, in order to account for the decreased statistical certainty with attributed populations less than 10,000.

III. Alternative Payment Methodology Targets

1. For purposes of meeting the "**Alternative Payment Methodology Target**" for calendar year 2019, health insurers subject to the Affordability Standards shall take such actions as necessary to have 50% of insured medical payments made through an alternative payment methodology throughout the entirety of the calendar year.
2. For purposes of meeting the "**Non-Fee-for-Service Target**" for calendar year 2019, health insurers subject to the Affordability Standards shall take such actions as necessary to have 10% of insured medical payments made through non-fee-for-service models for the entirety of calendar year 2019. By June 1st, 2019 each insurer shall report to OHIC on efforts being undertaken to achieve the 10% target, barriers encountered concerning the implementation of non-FFS payment models and responses to those barriers.
3. For purposes of meeting the "**Risk-Based Contract Target**" health insurers subject to the Affordability Standards shall take such actions as necessary to have:

³ A hospital-based ACO has ownership held in whole or in part by one or more hospitals.

- 30% of Rhode Island resident insured covered lives under Risk-Based Contracts for the entirety of calendar year 2019, including but not limited to contracts subject to the Minimum Downside Risk requirements (i.e., including any contracts with fewer than 10,000 lives).

IV. Identified Support for Value-Based Payment Reform

1. OHIC affirms its commitment to using its authority under the Rhode Island General Laws to encourage and direct health care system transformations which improve the quality, efficiency and affordability of health care in the state. During the first six months of 2019, OHIC will review its Affordability Standards and propose recommendations for revision. During the review of the Affordability Standards OHIC will place under consideration several issues that members of the Advisory Committee deemed salient, including but not limited to:

- A continued focus on the key drivers of the total cost of care;
- A focus on specialists in efforts to improve the delivery and cost of health care;
- Attention to reducing the provision of low-value care;
- The need to improve behavioral health care integration, quality, affordability and the application of APMs with behavioral health care providers; and
- Attention to plan design as a driver of consumer behavior and contributor to cost growth.

OHIC will continue to work toward the implementation of a primary care APM pilot program by 2020 and continue to engage insurers and primary care providers to ensure that payment models support the practice transformations which have taken place in the state over the last ten years. In addition, OHIC will consider ways to ease administrative burden and reduce clinician burnout.

2. OHIC has entered a Memorandum of Understanding with Medicaid to establish a program for oversight of risk-bearing provider organizations (RBPOs). At times throughout the history of the APM Advisory Committee, members have expressed concern at the lack of a state entity to certify that RBPOs possess the financial wherewithal to manage losses which may occur under Risk-Based Contracts. In the event of financially adverse experience under a Risk-Based Contract, an RBPO may find itself in a position of insolvency, thus harming the viability of the RBPO and posing deleterious consequences for patient access and continuity of care, and could have negative financial and network adequacy consequences for a payer. In 2019 OHIC will develop the parameters of a RBPO oversight program with the planned implementation date of July 2019. OHIC will collaborate with relevant stakeholders, including health care providers, insurers, and other interested parties over the course of the development process.

V. Conclusion

This 2019 Alternative Payment Methodology Plan is derived from the deliberations and input of the Alternative Payment Methodology Advisory Committee. It advances progress towards the goals set forth in the OHIC Affordability Standards.

Dated at Cranston, Rhode Island this 24th day of January, 2019.

A handwritten signature in cursive script that reads "Marie Ganim".

Marie Ganim, PhD
Health Insurance Commissioner
Office of the Health Insurance Commissioner